MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

FINDING OF EMERGENCY
ER-1-09
Community Provider Plan Designation Process

FINDING OF EMERGENCY

Pursuant to Section 11346.1 of the Government Code, the Managed Risk Medical Insurance Board (MRMIB) found at its January 29, 2009 meeting, that an emergency exists and that the immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety, or general welfare. A copy of the Finding of Emergency adopted by the Board is attached.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

MRMIB operates the Healthy Families Program (HFP), which provides health insurance for approximately 900,000 low-income children whose family incomes are at or below 250% of the federal poverty level net of applicable deductions and who are ineligible for Medi-Cal because their family income exceeds Medi-Cal income eligibility limits. (Insurance Code section 12693 et seq.) MRMIB provides the coverage to eligible children by contracting with health plans. (Ins. Code section 12693.26.) Participating health plans, in turn, contract with providers to provide the medical services. In its selection of participating plans, the Board must include plans that have contracts with traditional and safety net (T&SN) providers. (Ins. Code section 12693.37(b).) T&SN providers are those which historically serve low income and uninsured children, such as free or rural health clinics and county-owned and operated general acute care hospitals.[1]

In each county, the Board must designate a community provider plan (CPP) that is the participating health plan that has the highest percentage of T&SN providers in its network.[2] Applicants selecting a CPP receive a family contribution discount on their premiums. (Ins. Code section 12693.43(d).) The discounted premium is

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[1] The types of T&SN providers are more fully described in section 2699.6805(c).

[2] The term "community provider plan" means the participating health plan in each geographical area that has been designated by the board as having the highest percentage of traditional and safety net provides in its provider network. (Ins. Code section 12693.045.) The Board has determined that the applicable geographic area for the CPP designation is each county. (Cal. Code Regs., tit. 10, sec. 2699.6805.)

subsidized by MRMIB. The process gives an incentive for the plans to compete for the CPP designation because the family contribution discount encourages applicants to choose the CPP.

The CPP designation process is intended to promote important goals in providing health care to low-income children: (1) stability for the T&SN providers, which historically provide services to HFP-eligible children, (2) continuity of care for newly enrolled HFP subscribers because such subscribers are likely to have been uninsured and, therefore, more likely to have used T&SN providers, and (3) provision of care by providers that have cultural and linguistic competencies appropriate to the HFP-eligible population since T&SN providers are more likely to be located in areas which reflect HFP eligible subscribers' cultural and linguistic characteristics.

The HFP regulations set forth the process for the health plans' submission of data that MRMIB considers to determine which plan has the highest percentage of T&SN providers.[3] Each year, the Board compiles and makes available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic, and hospital T&SN providers that meet specified criteria. The CHDP list is compiled using data from the CHDP Paid Claims Tape and the clinic list is compiled using data from the Medi-Cal Paid Claims Tape. The hospital list is compiled using data from the Department of Health Care Services (DHCS) and the Office of Statewide Health Planning and Development (OSHPD). Plans have an opportunity to request revisions to the lists if the plans can demonstrate that a provider not on the list meets the criteria listed in the regulations (Cal. Code sections 2699.805(d)(1), (2) and (3).) After the revision period has expired, the Board compiles and makes available a final list for each county of CHDP, clinic and hospital T&SN providers. Each plan then uses the final list to indicate which of the providers are contracted with the plan. Finally, MRMIB calculates a T&SN score for each plan in each county and the plan with the highest score is designated the CPP.

On March 27, 2008 emergency regulations were approved by the Office of Administrative Law (OAL); on August 7, 2008, the Board approved regulation changes to the CPP designation process that changed the scoring methodology for the clinics and CHDP providers. The new methodology considered the volume of services provided by each clinic in the calculation of the clinic score. The regulations also changed the scoring methodology for CHDP providers such that the volume of services provided by the CHDP providers is included in the calculation. The intent of the new methodology was to ensure that higher volume T&SN providers were given a greater weight in the scoring than low volume providers. These regulations became effective on October 22, 2008.

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[3] See Cal. Code Regs., tit. 10, sec. 2699.6805.

In attempting to implement the new methodology for the 2009-10 benefit year which begins July 1, 2009, MRMIB staff concluded that the calculation of the clinic and CHDP scores cannot be done in conformance with the newly revised regulations. The data sources from which MRMIB develops the CHDP and clinic lists in order to assign percentages to each provider – the Medi-Cal Paid Claims Tape and CHDP Paid Claims Tape - do not include numbers of services provided by each provider. [4] Therefore, MRMIB cannot calculate a score based on the formula contained in the regulations for at least 22 of the 58 counties in California.

Existing regulations require the Board to designate a CPP in each county to be effective on the day the open enrollment transfers described in Section 2699.6621 take effect. The section requires an annual open enrollment period of at least forty-five (45) calendar days. As provided in section 2699.6500(h), the benefit year is defined as the twelve month period commencing July 1 of each year. The CPP designation must be made in sufficient time for the preparation and distribution of information to applicants about which plans will offer the family contribution discount. The information is critical to allow applicants to make informed choices for the next benefit year. As an operational matter, absent extraordinary circumstances, the CPP designation must be made in March and the information distributed to applicants in April.[5]

An emergency exists and immediate adoption of the attached proposed regulations is necessary because the data required by the present regulations does not exist. Therefore, the Board can not complete the scoring process and timely designate the CPP. This results in the Board being out of compliance with State statute requiring the designation of a CPP in each county. Not designating a CPP timely would cause serious harm to low income families because they would not be able to receive the family contribution discount for the 2009-10 benefit year..

AUTHORITY AND REFERENCE CITATIONS

Authority: Insurance Code section 12693.21

Reference: Insurance Code sections 12693.21, 12693.37, 12693.43 and 12693.065.

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[4] CHDP Paid Claims Tape pursuant to Cal. Code Regs., tit 10, sec 2699.6805(c)(1) and Medi-Cal Paid Claims Tape pursuant to Cal. Code Regs., tit 10, sec 2699.6805(c)(2).

[5] As a result of the budget crisis, by statute, for the benefit year 2008-09, the CPP designation was made on a different timeframe. See, Insurance Code section 12693.43. The Board anticipates that for the benefit year 2009-10, the usual timeframe described above will be utilized.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing Law: MRMIB administers the HFP to provide health insurance coverage for low-income uninsured children. The coverage is provided by contracting with health plans. By statute, MRMIB must take steps to assure a range of choices available to applicants and it must include plans whose provider networks include contracts with T&SN providers. In each county, the Board must designate a CPP. Applicants selecting a CPP are given a family contribution discount.

A summary of the proposed regulations' effect on existing law and regulations is as follows:

2699.6805(b).

Section 2699.6805(b) presently requires the Board to compile and make available a list for each county of all CHDP, clinic, and hospital T&SN providers that meet specified criteria by the first day of November. The proposed regulation would change the date when the Board releases the preliminary T&SN provider list. This change gives the Board flexibility as to when the list will be released within the month of November.

2699.6805(c)(2).

Section 2699.6805(c)(2) would remove the requirement that clinics listed on the Medi-Cal Paid Claims Tape provide at least (15) services and replaces it with the requirement that the clinics provide service to at least one child aged (1) through (18). This change reinstates the original method for determining which clinics will be placed on the list. This change is needed because the Medi-Cal Paid Claims Tape does not include data on the number of services provided by clinics that contract with health plans in certain counties.

2699.6805(e).

2699.6805(e) would delete the reference to the "30-day revision period". The 30-day revision period is covered in sections 2699.6805(d)(1), (2) and (3) and is unnecessary in 2699.6806(e). Additional language would clarify the date that the final list will be made available for the 2009-10 benefit year since the change in regulations would occur in the middle of the timeframe described in the present regulations.

2699.6805(f)(4).

2699.6805(f)(4) would be added to adjust the date for when plans must submit the list of the T&SN providers in their networks for the 2009-10 benefit year. The language is necessary to clarify the timeframe for the plans' submissions since the proposed change would occur in the middle of the timeframe described in the present regulations.

2699.6805(g)(1).

Section 2699.6805(g)(1) would remove the requirement to use the number of CHDP services provided and changes the methodology for calculating the CHDP score back to the original method of summing the percentages assigned to CHDP providers based on number of children served. This change is needed because data regarding the number of services provided by CHDP providers is not available for all counties.

2699.6805(g)(2).

2699.6805(g)(2) would reinstate the calculation method for computing the clinic percentage to that which was in effect prior to October 22, 2008. The new method is necessary because the data on number of services by provided by each clinic does not exist for all counties.

2699.6805(g)(2)(A) and (B).

2699.6805(g)(2)(A) and (B) would be deleted and replaced with 2699.6805(g)(2). The change is necessary because the calculation for the clinic score is being changed to the method in effect prior to October 22, 2008

2699.6805(g)(3).

2699.6805(g)(3) would clarify existing language. Specifically, the language is changed to explain that the percentages are assigned "pursuant to" subsection (c)(3), instead of "described in" the subsection. In addition, the subsection replaces the incorrect reference to (d)(3) with the correct reference to (f)(3).

Policy Statement: The objectives of the proposed regulations are to (1) provide the Board with the ability to comply with regulations to determine, by county, the plan that has the most Traditional and Safety Net providers in its network in order to designate the Community Provider Plan, (2) provide HFP applicants and members with a choice of low cost plans, (3) avoid disruption to families, and (4) avoid needless and excessive programmatic costs.

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: No.

Mandates on Local Agencies or School Districts: None.

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Non-discretionary Costs or Savings Imposed on Local Agencies: None.

Costs or Savings to Any State Agency: None.

Costs or Savings in Federal Funding to the State: None. The proposed regulation would simply provide the Board with flexibility as to the timeframe for designating the CPP and bases the calculation methodology for determining the CPP on readily available data.